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## **Table of Contents**

**State/Territory Name: Montana**

**State Plan Amendment (SPA) #: MT-14-0004-MM7**

This file contains the following documents in the order listed:

- 1) Approval Letter
- 2) Summary Form (with 179-like data)
- 3) Approved SPA Pages
- 4) Additional Attachments that are part of the state plan (delete if not applicable)

DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services  
1600 Broadway, Suite 700  
Denver, CO 80202-4967



## **Region VIII**

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March 07, 2013

Mary Dalton, Medicaid & Health Services Manager  
Montana Department of Health & Human Services  
1400 Broadway  
PO Box 202951  
Helena, MT 59620

Re: SPA MT-14-0004-MM7

Dear Ms. Dalton:

We have reviewed the proposed MAGI State Plan Amendment (SPA) submitted under transmittal number MT-14-0004-MM7. This SPA implements the new provision for MAGI Presumptive Eligibility for Hospitals.

Please be informed that this State Plan Amendment was approved March 6, 2014 with an effective date of January 1, 2014. We are enclosing the summary page and the amended plan page(s).

Montana should report its PE expenditures on Form CMS-64.9PE and/or Form CMS-64.9PE Waiver and only select from the (2) eligibility drop options, Low Income and/or Family Planning. Additionally prior period adjustments would be reported on the Form CMS-64.9PEP and/or the Form CMS-64.9 PEP Waiver.

If you have any questions regarding this SPA please contact Cindy Smith at 303-844-7041.

Sincerely,

/s/

Richard C. Allen  
Associate Regional Administrator  
Division for Medicaid and Children's Health Operations

Cc: Richard Opper, Department Director  
Duane Preshinger  
Jo Thompson

**Medicaid State Plan Eligibility: Summary Page (CMS 179)**

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**State/Territory name:** Montana**Transmittal Number:**

*Please enter the Transmittal Number (TN) in the format ST-YY-0000 where ST= the state abbreviation, YY= the last two digits of the submission year, and 0000 = a four digit number with leading zeros. The dashes must also be entered.*

MT-14-0004

**Proposed Effective Date**

01/01/2014

(mm/dd/yyyy)

**Federal Statute/Regulation Citation**

42 CFR 435.1110

**Federal Budget Impact**

	<b>Federal Fiscal Year</b>	<b>Amount</b>
<b>First Year</b>	2014	\$ 0.00
<b>Second Year</b>	2015	\$ 0.00

**Subject of Amendment**

Implementation of ACA changes for presumptive eligibility administered by hospitals allowed under the ACA. Hospitals will conduct presumptive for pregnant women; infants and children under age 19; parents and other caretaker relatives; and Former Foster Care Children. Montana will also do presumptive eligibility for Breast and Cervical Cancer Treatment program and our 1115 Waiver program, Plan First.

**Governor's Office Review**☐ Governor's office reported no comment☐ Comments of Governor's office received

Describe:

☐ No reply received within 45 days of submittal☐ Other, as specified

Describe:

Single State Agency

**Signature of State Agency Official****Submitted By:**

Mary Eve

**Last Revision Date:**

Feb 28, 2014

**Submit Date:**

Nov 4, 2013



# Medicaid Eligibility

OMB Control Number 0938-1148

OMB Expiration date: 10/31/2014

## Presumptive Eligibility by Hospitals

**S21**

42 CFR 435.1110

One or more qualified hospitals are determining presumptive eligibility under 42 CFR 435.1110, and the state is providing Medicaid coverage for individuals determined presumptively eligible under this provision.

☒ Yes ☐ No

☒ The state attests that presumptive eligibility by hospitals is administered in accordance with the following provisions:

☒ A qualified hospital is a hospital that:

☒ Participates as a provider under the Medicaid state plan or a Medicaid 1115 Demonstration, notifies the Medicaid agency of its election to make presumptive eligibility determinations and agrees to make presumptive eligibility determinations consistent with state policies and procedures.

☒ Has not been disqualified by the Medicaid agency for failure to make presumptive eligibility determinations in accordance with applicable state policies and procedures or for failure to meet any standards that may have been established by the Medicaid agency.

Assists individuals in completing and submitting the full application and understanding any documentation requirements.

☒ Yes ☐ No

☒ The eligibility groups or populations for which hospitals determine eligibility presumptively are:

☒ Pregnant Women

☒ Infants and Children under Age 19

☒ Parents and Other Caretaker Relatives

☒ Adult Group, if covered by the state

☒ Individuals above 133% FPL under Age 65, if covered by the state

☒ Individuals Eligible for Family Planning Services, if covered by the state

☒ Former Foster Care Children

☒ Certain Individuals Needing Treatment for Breast or Cervical Cancer, if covered by the state

☐ Other Family/Adult groups:

☐ Eligibility groups for individuals age 65 and over

☐ Eligibility groups for individuals who are blind

☐ Eligibility groups for individuals with disabilities

☐ Other Medicaid state plan eligibility groups

☐ Demonstration populations covered under section 1115

The state establishes standards for qualified hospitals making presumptive eligibility determinations.



# Medicaid Eligibility

☐ Yes ☒ No

☒ The presumptive period begins on the date the determination is made.

☒ The end date of the presumptive period is the earlier of:

The date the eligibility determination for regular Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made; or

The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

☒ Periods of presumptive eligibility are limited as follows:

☐ No more than one period within a calendar year.

☐ No more than one period within two calendar years.

☐ No more than one period within a twelve-month period, starting with the effective date of the initial presumptive eligibility period.

☒ Other reasonable limitation:

	Name of limitation	Description	
<b>+</b>	One period per pregnancy	Allow one presumptive period per pregnancy.	<b>X</b>
<b>+</b>	One period per calendar	Allow one presumptive period per calendar year for these groups: Parent/Caretaker Relative, Infants and Children under age 19, Former Foster Care and Breast & Cervical Cancer Treatment Individuals.	<b>X</b>

The state requires that a written application be signed by the applicant, parent or representative, as appropriate.

☒ Yes ☐ No

☐ The state uses a single application form for Medicaid and presumptive eligibility, approved by CMS.

☒ The state uses a separate application form for presumptive eligibility, approved by CMS. A copy of the application form is included.

**An attachment is submitted.**



# Medicaid Eligibility

- ☐ The presumptive eligibility determination is based on the following factors:

The individual's categorical or non-financial eligibility for the group for which the individual's presumptive eligibility is being determined (e.g., based on age, pregnancy status, status as a parent/caretaker relative, disability, or other requirements specified in the Medicaid state plan or a Medicaid 1115 demonstration for that group)

- ☐ Household income must not exceed the applicable income standard for the group for which the individual's presumptive eligibility is being determined, if an income standard is applicable for this group.

☒ State residency

☒ Citizenship, status as a national, or satisfactory immigration status

- ☒ The state assures that it has communicated the requirements for qualified hospitals, and has provided adequate training to the hospitals. A copy of the training materials has been included.

**An attachment is submitted.**

## PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1148. The time required to complete this information collection is estimated to average 40 hours per response, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.



## Proof of Temporary Coverage for Presumptive Eligibility

Dear Provider:

The person(s) listed below has temporary health coverage through Presumptive Eligibility (PE). Temporary coverage may last between 30 and 60 days depending on the effective date of coverage shown (below). To ensure payment, providers must verify eligibility prior to providing services and submitting claims. If you have questions concerning Presumptive Eligibility, please call the Human and Community Services office, 1-877-543-7669, ext.2869 OR ext. 3098.

Verify Presumptive Eligibility via:

- Web Portal at [www.mtmedicaid.org](http://www.mtmedicaid.org) (click on *Montana Access to Health* link);
- FAX Back at 1-800-714-0075 (do not FAX the completed PE application to this FAX number); or
- Automated Voice Response at 1-800-714-0060

Services included under temporary coverage are the same as those available under regular program coverage.

**NOTE:** Social Security Numbers are requested **but are not required**.

Name (First - Middle Initial - last)	Social Security Number <u>AND</u> Date of Birth mm/dd/yyyy	Effective Date of Coverage mm/dd/yyyy	<u>Check the appropriate coverage group</u>					
			HMK Plus	HMK	Former Foster Care (ages 18 up to 26)	Parent/ Caretaker Relative Medicaid	Pregnant Woman	Breast & Cervical Cancer

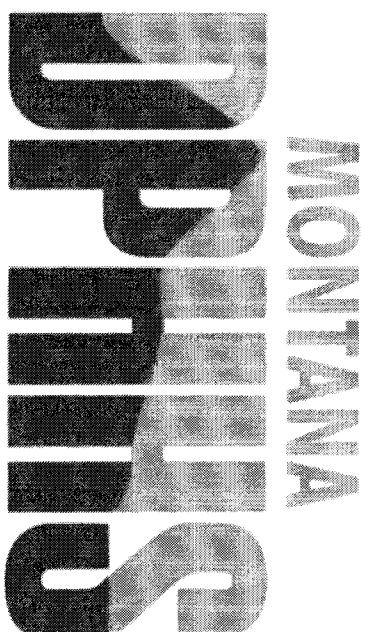
Name of Qualified Entity Determining Presumptive Eligibility (Please Print)

Date

Signature of Qualified Entity

**QUALIFIED ENTITY:** Within 5 days of Determination, SCAN PE Application and Proof of Temporary Coverage form, then create a secure ePass account at [transfer.mt.gov](http://transfer.mt.gov), and email scanned documents to: [HHSPresumptive@mt.gov](mailto:HHSPresumptive@mt.gov) – OR FAX same documents to: 1-877-418-4533.

Human and Community Services Division, State of Montana, PO Box 202925, Helena MT 59620-2925



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Department of Public Health & Human Services

# Presumptive Eligibility Training

*Streamlining Healthcare for Montanans*

Human and Community Services Division, DPHHS  
PO Box 202925, Helena, Montana 59620-2925

Website: [www.dphhs.mt.gov](http://www.dphhs.mt.gov) ♦ E-mail: [tsmith@mt.gov](mailto:tsmith@mt.gov)  
1-877-543-7669, x3098 (Free call)

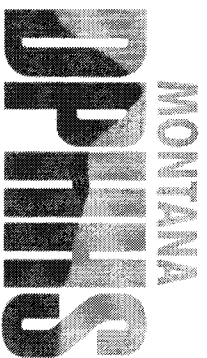


## *Presumptive Eligibility--Streamlining Healthcare for Montanans*

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# **You Make It Happen!**

- ❖ As a Qualified Entity (QE), you have many opportunities to make a real difference for the people you serve. Access to health care is critical for uninsured or underinsured persons when faced with sudden and serious health care conditions.
- ❖ After taking this training, you will be trained and certified to make accurate, complete and timely Presumptive Eligibility (PE) determinations so eligible people can receive temporary health care coverage for a short period of time. Reimbursement for your facility, and the family's peace of mind depend upon your due diligence and attention to detail.
- ❖ *We value your participation in the Presumptive Eligibility process. You are an ambassador for health care. Thank you for your commitment to Montanans!*



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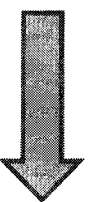
Department of Public Health & Human Services

*Presumptive Eligibility--Streamlining Healthcare for Montanans*

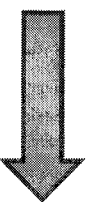
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## New or Changing Populations for PE

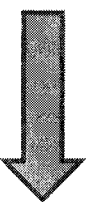
Beginning January 1, 2014, hospitals and other designated facilities participating with Medicaid are able to offer PE to more people. Prior to 2014, PE was available for children and pregnant women. Now the following populations have PE coverage as an option if they meet eligibility requirements. The hospital/facility must participate with Medicaid and must agree to make determinations for every group listed:



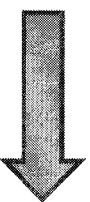
Children (HMK *Plus* and HMK)



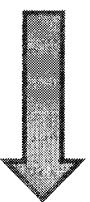
Former Foster Care Children (ages 18 up to 26)



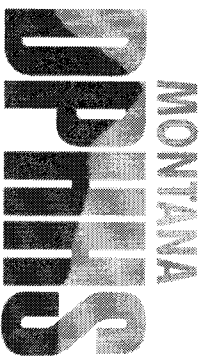
Parent/Caretaker Relative Medicaid



Pregnant Woman (Ambulatory Prenatal Care)



Breast and Cervical Cancer



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## *Presumptive Eligibility--Streamlining Healthcare for Montanans*

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### Definitions

**HMK *Plus*** – (Healthy Montana Kids *Plus*), formerly called Children’s Medicaid

- **Children UP TO age 19.** See *Income Calculation Tool* for Household Income levels.

**HMK** – (Healthy Montana Kids), formerly called Children’s Health Insurance Program (CHIP)

- **Children UP TO age 19.** See *Income Calculation Tool* for Household Income levels.
- **Applicants cannot have other health insurance and receive HMK.**

#### **Former Foster Care**

- For individuals who **were in Foster Care and receiving Medicaid** when they turned **18**
- May apply if currently age **18 UP TO age 26**
- No Income limit or resource/asset test
- Should be evaluated for PE as an individual even if living in a household with other family members

#### **Parent/Caretaker Relative Medicaid**

- For individuals who live together and are related by Marriage and/or Parentage.
- The parent or caretaker relative **must have a related dependent child under age 19 living with them in the home to be eligible.** See *Income Calculation Tool* for Household Income levels.

## *Presumptive Eligibility--Streamlining Healthcare for Montanans*

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### **Definitions, Continued**

#### **Pregnant Woman**

- For Pregnant women presenting for services prior to delivery. See ***Income Calculation Tool*** for Household Income levels. A pregnant woman may be eligible for PE more than once in 12 months if they are pregnant more than once in that 12-month period.

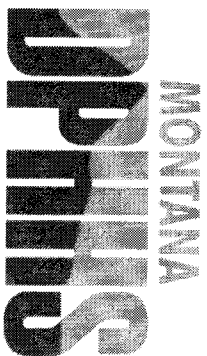
#### **Breast and Cervical Cancer**

- For women (ages 19 through 64) presenting for services after screening at a designated Montana Breast and Cervical Health Program facility AND after receiving diagnosis and treatment options for breast and/or cervical cancer.

- A **Montana Breast and Cervical Screening Form**, **Enrollment Form**, and the

**Montana Breast and Cervical Cancer Treatment Program Medicaid Referral** form must be presented to be eligible for PE.

- Income and Household Size do not need to be evaluated for PE since they are reviewed during the Breast and Cervical Cancer Screening process.
- Applicants cannot have other insurance which covers breast or cervical cancer treatment.



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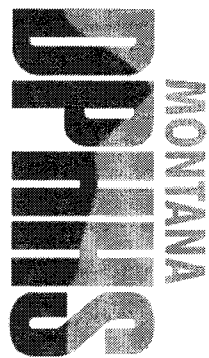
## *Presumptive Eligibility--Streamlining Healthcare for Montanans*

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# What Is Presumptive Eligibility?

### Immediate temporary health coverage for eligible individuals

- Recipients are allowed ONE PE period every 12 months (dated from the most recent PE effective date) OR once per pregnancy. (A pregnant woman may be eligible more than once in 12 months if they have more than one pregnancy during that 12-month period).
- When applying for Presumptive Eligibility, Applicants **MUST** be provided with the "Application for Health Coverage" and informed of documentation requirements. QEs are encouraged to assist applicants as much as possible in applying for long term coverage.
- PE begins the date a Qualified Entity makes a PE determination, and lasts until either the date a complete eligibility determination is made based on a full health coverage application, OR until the last day of the month following the month PE began. Qualified Entities must explain coverage options to PE recipients:
  - Short term coverage is provided under Presumptive Eligibility, and
  - Longer term coverage is available to eligible persons who complete and submit the "Application for Health Coverage" and required documentation.



Presumptive Eligibility--Streamlining Healthcare for Montanans

## Step 1 – Verify Coverage Status Web Portal - [www.mtmedicaid.org](http://www.mtmedicaid.org)

★ Verify if the person has current coverage

mt.gov

Montana's Official State Website

Montana Access to Health Web Portal

HOME INQUIRIES SUBMISSIONS RETRIEVALS MANAGE USERS MY ACCESS

Eligibility Inquiry Response

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES

Exit | Help

Mayo Dermatology

Client Demographic Information

Client Original ID:

Client Current ID:

Client Member ID:

Name:

Address:

City:

County Code:

State:

Zip Code:

Date of Birth:

Gender Code:

NPI of Provider ID:

Date of Service:

Valid Request Indicator:

Reject Reason Code:

Follow-up Action Code:

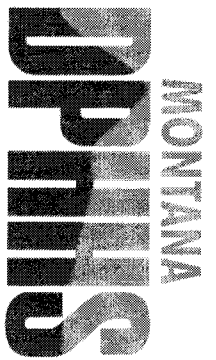
Date of Death:

Trace Number:

Eligibility Spans

Service Type Code	Insurance Code	Payer Name	Plan Coverage Description	Eligibility Effective Date	Eligibility End Date
30: Health Benefit Plan Coverage	MC: Medicaid	Medicaid/HMKPlus Basic Coverage		02/01/2012	12/31/2013

In this example,  
the person has  
HMK Plus coverage  
from 2/1/12 -  
12/31/13.



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## Presumptive Eligibility--Streamlining Healthcare for Montanans

★ Verify if the person had Presumptive Eligibility within the past 12 months (on or after a year prior to the current date)

mt.gov

Montana's Official State Website

Department of Public Health & Human Services

Montana Access to Health Web Portal

HOME INQUIRIES SUBMISSIONS RETRIEVALS MANAGE USERS MY ACCESS

Home > Inquiries > Eligibility Inquiry > Eligibility Inquiry Response

Eligibility Inquiry Response

Exit | Help

MONTANA MEDICAID TEST 1

### Client Demographic Information

Client Original ID: 0001110902

Client Current ID: 01/15/2014

Client Member ID: 01/15/2014

Name: Valid Request Indicator

Address: Request Reason Code

City: Follow up Action Code

County: Date of Death

State: Trace Number

Zip Code:

Date of Birth:

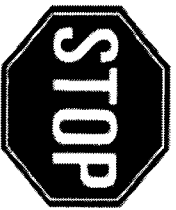
Gender Code:

### Eligibility Spans

Service Type Code	Insurance Type Code	Payer Name	Plan Coverage Description	Eligibility Effective Date	Eligibility End Date
30: Health Benefit Plan Coverage	OT: Other	HMK/CHIP	Presumptive Eligible	01/15/2014	02/28/2014

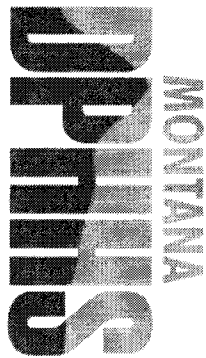
### About HMK/HMKPlus

In this example, the person had HMK Presumptive Eligibility coverage 1/15/14-2/28/14. This person can't receive PE benefits again until 1/15/2015



**Persons currently covered under Medicaid, HMK, or HMK Plus do not need PE.**

**Those who had PE within the past 12 months (with a PE effective date on or after a year prior to the current date) are not eligible for PE, but the "Application for Health Coverage" should be offered. A pregnant woman may be eligible for PE more than once in 12 months if they are pregnant more than once during that 12-month period.**



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## Presumptive Eligibility--Streamlining Healthcare for Montanans

### Step 2

#### The Presumptive Eligibility Application

➤ The APPLICANT (or their representative) completes Applicant Information:



This application is used for Presumptive Eligibility (PE) determinations for:

- Children (HNAK Plus and HNAK)
- Former Foster Care Children, ages 18 up to 25
- Parent/Grandparent Relative Medicaid
- Pregnant Woman
- Breast & Cervical Cancer

For ongoing coverage, applicants may:

- Apply online at [www.healthcare.gov](http://www.healthcare.gov) or phone 1-800-318-2596
  - Apply online at [www.apply.mt.gov](http://www.apply.mt.gov) or phone 1-888-706-1535
  - Apply by mail using a paper Application for Health Coverage.
- Mail application to: P.O. Box 202925, Helena, MT 59620-2925

#### Applicant Information - Please PRINT CLEARLY.

First/Last Name:

Home Address:

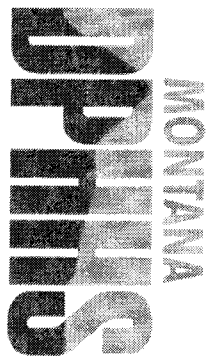
City/State/ZIP:

Mailing Address (if Different):

City/State/ZIP:

Home or Cell Phone:

Message Phone:



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## Presumptive Eligibility--Streamlining Healthcare for Montanans

### The PE Application, continued

Applicants complete the Household Information Box and the applicable questions below the box:

**Household Information** -- Complete for every person living in the household. List adults first, then children. Social Security Numbers are requested but are not required. \*U.S. Citizenship and \*\*Qualified Non-Citizen status ONLY need to be included for persons applying for Presumptive Eligibility. \*\*Answer ONLY for HMK.

Name (First - Middle Initial - Last)	Relationship to Applicant	Apply for PE? (Y/N)	Social Security Number	Date of Birth (mm/dd/yyyy)	Gender (M/F)	*U.S. Citizen (Y/N)	**Qualified Non- Citizen (Y/N)	Montana Resident (Y/N)	**Has Health Insurance (Y/N)
1	[self]								
2									
3									
4									
5									
6									

Is anyone in the household pregnant? ☐ Yes ☐ No If "Yes", who? \_\_\_\_\_ Date Due: \_\_\_\_\_ How many unborn? \_\_\_\_\_

Was anyone in foster care and receiving Medicaid at age 18? ☐ Yes ☐ No If "Yes", who? \_\_\_\_\_

Applicant: Please also complete Household Income Information and Signature on Next Page.

January 2014 - Page 1



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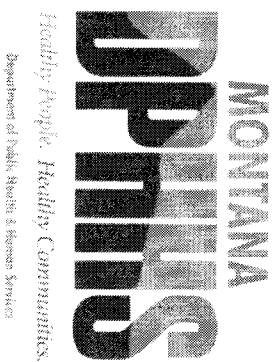
## *Presumptive Eligibility--Streamlining Healthcare for Montanans*

Immigrant Applicants must review the Page 3 Addendum to respond to Qualified Non-Citizen column on Page 1:

Those who are in ANY of the following groups are considered a Qualified Non-Citizen:

- Lawful Permanent Residents (LPR/Green Card Holder)\*\* -- SEE FURTHER INFORMATION, BELOW
- Asylees
- Refugees
- Cuban/Haitian entrants
- Paroled into the U.S. for at least one year
- Conditional entrant granted before 1980
- Battered non-citizens, spouses, children, or parents
- Victims of trafficking and his or her spouse, child, sibling, or parent or individuals with a pending application for a victim of trafficking visa
- Granted withholding of deportation
- Member of a federally recognized Indian tribe or American Indian born in Canada
- Children lawfully residing in the state of Montana (lawfully present and otherwise eligible for HMK Plus or HMK in the state, including being a state resident)

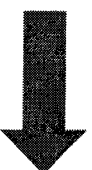
**\*\*** In order to get Medicaid coverage under current law, most adult Lawful Permanent Residents or Green card holders have a 5-year waiting period. These residents must wait 5 years after receiving "qualified" immigration status before they are eligible for Medicaid. There are exceptions -- Lawful Permanent Residents who don't have to wait 5 years -- such as people previously identified as refugees or asylees.



*Presumptive Eligibility--Streamlining Healthcare for Montanans*

## Income Information and Signature

Finally, the Applicant completes the Household Income Information box and signs the application:



### Household Income Information and Applicant Signature

**Earned Income** – List this MONTH'S total gross wages before taxes for each person; **Unearned Income** – List all monthly unearned income (i.e., Unemployment, Social Security, Pensions, Interest/Dividends) for each person. (Do not include Child Support or Worker's Comp)

First Name	Earned Income Total	Unearned Income Total	TOTAL (Monthly Gross)

COMBINED TOTAL MONTHLY GROSS INCOME = \$ \_\_\_\_\_

(Applicant OR Parent/Guardian/Other) – I understand the questions on this application and the penalty for withholding or giving false information. I certify, under penalty of perjury, all my answers are correct and complete to the best of my knowledge. I understand the information provided on this application can be used to establish identity for children under age 16.

Applicant Name \_\_\_\_\_ (Please Print) Applicant Signature \_\_\_\_\_

(Presumptive Eligibility may last 60 days or less and is limited to once every 365 days OR once/pregnancy).

## *Presumptive Eligibility--Streamlining Healthcare for Montanans*

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### **Pregnant Woman -- Who Counts in Household Size?**

**For a Pregnant Woman**, include the woman, the unborn child(ren), the father of the unborn (if married and present in the household), and any other children (of the unborn's married parents) under age 19 who live in the household. Some examples:

- Ann is a single mother with one child and has a significant other in the household. She is pregnant with one child. For this household, **count only Ann, her child, and the unborn child (3)**. Do not count the significant other OR his income because he and Ann are not married.
- Julie and her husband are expecting their first child, and are living in the same household. **This household would include Julie, her husband, and the unborn (3)**.
- Mary and her husband, Bob, have 2 children and Mary is pregnant. They are living in the same household with Mary's parents, who require living assistance. **Count Mary, Bob, their 2 children, and the unborn in this household (5)**.



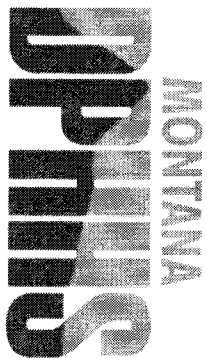
## *Presumptive Eligibility--Streamlining Healthcare for Montanans*

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### **For HMK, HMK Plus, and Parent/Caretaker Relative Medicaid -- Who Counts in Household Size?**

Include all those on the application connected by **Marriage** or **Parentage** who live in the household, **along with unborn children**, including Natural, Adoptive or Step Parents and birth, adoptive or step children under age 19, as well as unborn children of these persons. **DO NOT INCLUDE** other adult relatives who file their own tax return. Examples:

- Pamela, her significant other Dan, Pamela's two children, and Pamela and Dan's unborn child **are counted as a Household of 4**. Dan and his income are not counted. **After** the child is born, Dan and his income may be counted.
- Lily, Rose, and Paul live with their maternal grandparents and are not adopted by the grandparents. **Only the three children** are counted for this household (and only income the children receive is used for income purposes).
- Susan has three children, including an 18-year old daughter who just had a baby. Her brother Michael and his son live with Susan and her children and grandchild. **Count Susan, her children, and the baby** for a household of 5. Michael and his son are not counted because they are not connected by Marriage or Parentage.



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## Presumptive Eligibility--Streamlining Healthcare for Montanans

### Step 3

### Making a PE Determination

Complete the **ENTIRE** box "FOR OFFICE USE ONLY". Copy "Combined Total Monthly Gross Income" figure from the applicant's Income Information box. Count how many people are in the household and record the number under Household Size in the box shown below. Compare Combined Total Monthly Gross Income to Current Income Calculation Tool (next slide) based on household size for the program being considered for each individual. Once eligible individuals are identified, enter their names, etc. on the "Proof of Temporary Coverage" form.

#### FOR OFFICE USE ONLY – Qualified Entity must complete all information below:

COMBINED TOTAL MONTHLY GROSS INCOME for Household: \$ \_\_\_\_\_ \*\* Household Size \_\_\_\_\_

(\*\* Compare this amount to the Income Calculation Tool for the appropriate category of applicant(s) based on household size, then finalize determination).

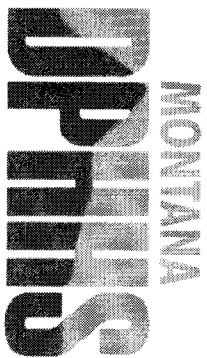
DATE DETERMINED (mm/dd/yyyy) \_\_\_\_\_ Facility \_\_\_\_\_

QE Signature \_\_\_\_\_

QE Name (print) \_\_\_\_\_

QE Phone \_\_\_\_\_ QE FAX \_\_\_\_\_ QE Email \_\_\_\_\_

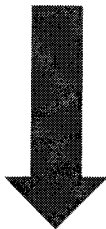
Within 5 days of Determination, SCAN application and Proof of Temporary Coverage form, then create a secure ePass account at [transfer.mt.gov](http://transfer.mt.gov), and email scanned documents to: [HHSPresumptive@mt.gov](mailto:HHSPresumptive@mt.gov) – **OR FAX** same documents to: 1-877-418-4533.



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## Presumptive Eligibility--Streamlining Healthcare for Montanans

# Current Income Calculation Tool



**Compare Combined  
Total Monthly Gross  
Income to Current  
Income Calculation  
Tool based on  
Household Size for  
the program being  
determined. Record  
Family Size in box  
"FOR OFFICE USE  
ONLY".**

Montana Presumptive Eligibility Income Calculation Tool -- Effective January 1, 2014					
HOUSEHOLD SIZE (See notes at bottom of page for who to count for household size)	Maximum Monthly Adjusted Gross Income HMK Plus Ages <19 (Other insurance allowed)	Maximum Monthly Adjusted Gross Income HMK Ages <19 (NO other insurance allowed)	Maximum Monthly Adjusted Gross Income Parent/Caretaker Relative Medicaid (Other insurance allowed) (Household MUST have child under age 19 related to adults)	Maximum Monthly Adjusted Gross Income Pregnant Woman (Other insurance allowed)	Maximum Monthly Adjusted Gross Income Former Foster Care Children Ages 18 UP TO 26 (Other insurance allowed) Breast and Cervical Cancer (No other insurance allowed which covers breast or cervical cancer treatment)
1	\$1,417	\$2,507	\$501	\$1,551	N/A
2	\$1,913	\$3,438	\$672	\$2,094	N/A
3	\$2,408	\$4,329	\$842	\$2,636	N/A
4	\$2,904	\$5,220	\$1,014	\$3,179	N/A
5	\$3,400	\$6,111	\$1,185	\$3,722	N/A
6	\$3,896	\$7,003	\$1,357	\$4,265	N/A
7	\$4,392	\$7,893	\$1,528	\$4,807	N/A
8	\$4,888	\$8,785	\$1,698	\$5,350	N/A
9	\$5,384	\$9,676	\$1,819	\$5,893	N/A

WHO TO COUNT FOR HOUSEHOLD SIZE: For Foster Care, count ALL the individuals. For Parental Medicaid, include the woman, the unborn child(ren), the father of the unborn child, and any other children of the household married to the father under age 18 who live in the household. For HMK, HMK Plus, or Medicaid, include all those on the application connected by marriage or kinship who live in the household along with unborn children, adopted, parent, partner, spouse, or child. Dependent children living in the household (with, spouse, or partner) are counted. For Medicaid, include all children under 19 and unborn children of these parents. A significant other who is the parent of a child(ren) in the household (other than unborn) should be counted. DO NOT include other adult relatives who file their own tax return. For Breast and Cervical Cancer, income and household size do not need to be evaluated for PE. If they are reviewed during the Breast and Cervical Cancer Screening process.

(Include calculation of income for each household size. Enter all 3 separate for separate income plus an automatic addition of 5% or 100% per, according to household size.)

**NOTE:** Applicants cannot have HMK coverage if they have other insurance (double check if applicant checked "has health insurance" on 1<sup>st</sup> page of PE Application, last column). Applicants cannot have Breast and Cervical Cancer PE coverage if their insurance plan covers breast or cervical cancer treatment or if they do not provide the needed paperwork.



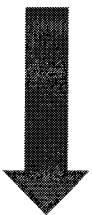
## Step 4

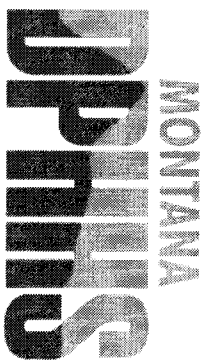
### Proof of Temporary Coverage for Presumptive Eligibility

- Review the “For Office Use Only” box to assure the QE completed all fields.

- **Make copies of the PE Application **AND** this Proof of Temporary Coverage form for the applicant.**

***The newly eligible PE enrollee uses the Proof of Temporary Coverage form in lieu of a member ID card. The form signifies PE enrollment to other health care providers.***

[illegible]



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## *Presumptive Eligibility--Streamlining Healthcare for Montanans*

### Step 5

### Follow Up and SCAN or FAX

- Provide the applicant(s) with information about accessing benefit information online. This information is available through:

[medicaid.mt.gov/membersguide.pdf](http://medicaid.mt.gov/membersguide.pdf) -- use for HMK Plus (Children's Medicaid), Parent/

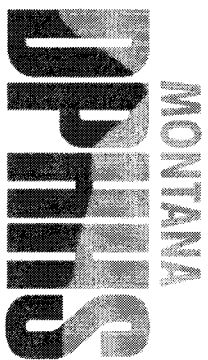
Caretaker Relative Medicaid, Former Foster Care, Pregnant Woman, and Breast &

Cervical Cancer benefit information

<http://hmk.mt.gov/hmkresources.shtml> (click on HMK Member Handbook) -- use for

Healthy Montana Kids (CHIP) benefit information

- Within 5 days of the date of determination, SCAN the PE application and Proof of Temporary Coverage form, then create a secure ePass account at [transfer.mt.gov](http://transfer.mt.gov), and email scanned documents to: [HSPresumptive@mt.gov](mailto:HSPresumptive@mt.gov), OR
- FAX the same documents to Central Office at 877-418-4533
- Keep a copy of your email with SCANNED documents attached, **OR** your FAX verification sheet with all faxed materials, in the event the State does not receive them. You should receive a faxed copy of the State's applicant enrollment letter within ten days. If you do not receive the letter, call Central Office at 877-543-7669 to confirm whether your SCAN or FAX was received and processed.



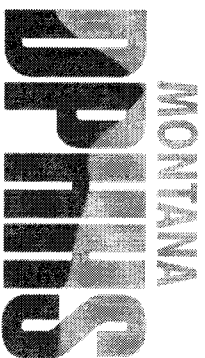
## *Presumptive Eligibility--Streamlining Healthcare for Montanans*

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### Follow Up, continued

#### **IMPORTANT! FURTHER APPLICATION ASSISTANCE REQUESTED!**

- Explain to applicants they will receive a letter within approximately 10 days confirming their PE enrollment.
- Provide the applicant a copy of the **Application for Health Coverage**, along with applicable appendices (Appendix A – Health Coverage from Jobs; Appendix B – American Indian/Alaska Native Family Member; or Appendix C – Authorized Representative Consent Form); and
- Assist or refer them to the appropriate contact in your facility who will assist them with completing the application, gathering any needed verifications, AND submitting the “Application for Health Coverage” to the State of Montana.
- Reinforce with the applicant the PE application is the first step in applying for ongoing coverage, and they may be contacted if additional information is necessary.



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Department of Public Health & Human Services

## *Presumptive Eligibility--Streamlining Healthcare for Montanans*

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### **Notes and Contact Information**

**Prior to submitting claims, verify the Presumptive Eligibility span is active by:**

**Web Portal - [www.mtmedicaid.org](http://www.mtmedicaid.org) (see "Eligibility Spans")**

**FAX Back - 1-800-714-0075**

**Automated Voice Response - 1-800-714-0060**

#### **Contact Us**

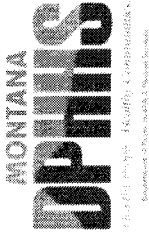
**Please call at any time if you have questions, need training or additional supplies, or need to verify any information about Presumptive Eligibility:**

**Trinda Smith**

**406-444-3098**

**1-877-543-7669, ex. 3098**

**[tsmith@mt.gov](mailto:tsmith@mt.gov)**



# PRESUMPTIVE ELIGIBILITY (PE) APPLICATION ONLY

This application is used for Presumptive Eligibility (PE) determinations for:

- Children (HMK Plus and HMK)
- Former Foster Care Children, ages 18 up to 26
- Parent/Caretaker Relative Medicaid
- Pregnant Woman
- Breast & Cervical Cancer

For ongoing coverage, applicants may:

- Apply online at [www.healthcare.gov](http://www.healthcare.gov); or phone 1-800-318-2596
- Apply online at [www.apply.mt.gov](http://www.apply.mt.gov) or phone 1-888-706-1535
- Apply by mail using a paper **Application for Health Coverage**.  
Mail application to: P.O. Box 202925, Helena, MT 59620-2925

## Applicant Information - Please PRINT CLEARLY.

First/Last Name:	
Home Address:	City/State/ZIP:
Mailing Address (if Different):	City/State/ZIP:
Home or Cell Phone:	Message Phone:

## Household Information

-- Complete for every person living in the household. List adults first, then children. Social Security Numbers are requested but are not required. \*U.S. Citizenship and \*Qualified Non-Citizen status ONLY need to be included for persons applying for Presumptive Eligibility. \*\*Answer ONLY for HMK.

	Name (First - Middle Initial - Last)	Relationship to Applicant	Apply for PE? (Y/N)	Social Security Number	Date of Birth (mm/dd/yyyy)	Gender (M/F)	*U.S. Citizen (Y/N)	SEE PAGE 3 ADDENDUM *Qualified Non- Citizen (Y/N)	Montana Resident (Y/N)	**Has Health Insurance (Y/N)
1		(self)								
2										
3										
4										
5										
6										

Is anyone in the household pregnant? Yes No If "Yes", who? Date Due How many unborns?

Was anyone in Foster Care and receiving Medicaid at age 18? Yes No If "Yes", who?

Applicant: Please also complete Household Income Information and Signature on Next Page.

TN: MT-14-0004-MM7

Approval Date: 03/06/2014

January, 2014 - Page 1  
Effective Date: 01/01/2014

### Household Income Information and Applicant Signature

**Earned Income** -- List this MONTH'S total gross wages before taxes for each person; **Unearned Income** -- List all monthly unearned income (i.e., Unemployment, Social Security, Pensions, Interest/Dividends) for each person. (Do not include Child Support or Worker's Comp)

First Name	Earned Income Total	Unearned Income Total	TOTAL (Monthly Gross)

COMBINED TOTAL MONTHLY GROSS INCOME = \$ \_\_\_\_\_

(Applicant OR Parent/Guardian/Other) – I understand the questions on this application and the penalty for withholding or giving false information. I certify, under penalty of perjury, all my answers are correct and complete to the best of my knowledge. I understand the information provided on this application can be used to establish identity for children under age 16.

Applicant Name \_\_\_\_\_ Applicant Signature \_\_\_\_\_  
(Please Print)

(Presumptive Eligibility may last 60 days or less and is limited to once every 365 days OR once/pregnancy).

### FOR OFFICE USE ONLY – Qualified Entity must complete all information below:

COMBINED TOTAL MONTHLY GROSS INCOME for Household: \$ \_\_\_\_\_ \*\* Household Size \_\_\_\_\_

(\*\*Compare this amount to the Income Calculation Tool for the appropriate category of applicant(s) based on household size, then finalize determination).

DATE DETERMINED (mm/dd/yyyy) \_\_\_\_\_ Facility \_\_\_\_\_

QE Signature \_\_\_\_\_

QE Name (print) \_\_\_\_\_

QE Phone \_\_\_\_\_ QE FAX \_\_\_\_\_ QE Email \_\_\_\_\_

Within 5 days of Determination, SCAN application and Proof of Temporary Coverage form, then create a secure ePass account at [transfer.mt.gov](http://transfer.mt.gov), and email scanned documents to: [HHSPresumptive@mt.gov](mailto:HHSPresumptive@mt.gov) – OR FAX same documents to: 1-877-418-4533.

# Presumptive Eligibility Application Addendum for Qualified Non-Citizens

ALL PERSONS WHO ARE IMMIGRANTS NEED TO REVIEW THE FOLLOWING INFORMATION TO DETERMINE IF THEY ARE A QUALIFIED NON-CITIZEN; THEN THEY SHOULD MARK THE APPROPRIATE RESPONSE ON PAGE 1.

Those who are in ANY of the following groups would be considered a Qualified Non-Citizen:

- Lawful Permanent Residents (LPR/Green Card Holder)\*\* -- SEE FURTHER INFORMATION, BELOW
- Asylees
- Refugees
- Cuban/Haitian entrants
- Paroled into the U.S. for at least one year
- Conditional entrant granted before 1980
- Battered non-citizens, spouses, children, or parents
- Victims of trafficking and his or her spouse, child, sibling, or parent or individuals with a pending application for a victim of trafficking visa
- Granted withholding of deportation
- Member of a federally recognized Indian tribe or American Indian born in Canada
- Children lawfully residing in the state of Montana (lawfully present and otherwise eligible for Medicaid or HMK in the state, including being a state resident)

\*\*In order to get Medicaid coverage, under current law most ADULT Lawful Permanent Residents or green card holders have a 5-year waiting period. This means they must wait 5 years after receiving "qualified" immigration status before being eligible for Medicaid. There are also exceptions -- Lawful Permanent Residents who don't have to wait 5 years -- such as people who used to be refugees or asylees.

Montana has removed the 5-year waiting period to cover lawfully residing children who are otherwise eligible for Medicaid or HMK. A child is "lawfully residing" if lawfully present and otherwise eligible for Medicaid or HMK in the state (including being a state resident).

**NOTE:** Immigrants who are qualified non-citizens are generally eligible for Medicaid and Children's Health Insurance Program (HMK) coverage IF they are otherwise eligible for Medicaid and HMK in the state, that is, if they meet Montana's income eligibility rules.